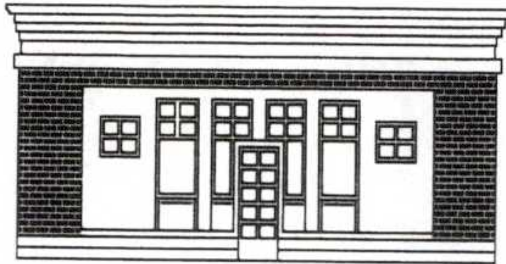
PATIENT AUTHORIZATION FORM

MT. AIRY FAMILY PRACTICE



I authorize release of any medical information necessary to process insurance claims for balance due Mt. Airy Family Practice and or it's providers. I also authorize payment of medical benefits to Mt. Airy Family Practice and/or it's providers for services rendered. I agree to accept responsibility for any deductibles or co-payments and for any balance due not covered by my insurance carrier.

Signature:____ Date:__________________________

Patient Name (printed):_________________________________

Name:______________________________ Date of Birth:______________ Today's Date:______

MEDICAL HISTORY

Please circle if you have any problems with or are presently concerned with any of these:

High blood pressure	Asthma	Blood in stool	Kidney disease/stones
Diabetes	Bronchitis	Ulcers/gastritis	Difficulty urination
Cancer	Pneumonia	Change in bowel habits	Arthritis
Heart Disease	Persistent Cough	Weight gain/loss	Low Back problems
Chest Pain or tightness	TB (tuberculosis)	Hemorrhoids	Skin diseases
Shortness of Breath	Abdominal discomfort	Gall bladder disease	Blood disorders
Swollen Ankles	Indigestion	Hepatitis or jaundice	Sexually transmitted diseases
Palpitations	Nausea	Thyroid disease	Anemia
Lightheadedness	Vomiting	Head or Neck radiation treatment	Gout
Rheumatic Fever	Diarrhea	Colitis	Depression
Frequent Urination	Constipation	Anxiety	Other:____________
Headaches	Hay fever		

PLEASE LIST AND SUPPLY THE DATES OF:

Operations:______________ ____________________ ____________________

Hospitalizations: *(Other than surgery)* ______________ ____________________

Do you take any medications (prescription or over the counter)? No ___ Yes ____

Name of medicine	Dose	How long have you taken this medicine?	Reason for taking

Latex Allergy ( ) No ( ) Yes If yes, how do you react? ______________________________
ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES ( ) No ( ) Yes
If yes please list what you are allergic to and how you react.____

____

____

____

HABITS

Do you wear seatbelts? ( ) No ( ) Yes If no, why not?__________________________
Do you exercise? ( ) No ( ) Yes
Do you have smoke detectors? ( ) No ( ) Yes If no, why not?__________________________
Do/Did you smoke? ( ) No ( ) Yes If yes, how many packs per day?______________
Do you use illicit drugs? ( ) No ( ) Yes If yes, what kind and how long?______________
Do you drink: Alcoholic beverages? ( ) No ( ) Yes If yes, how may per week?________________
Coffee or tea? ( ) No ( ) Yes If yes, how may per week?________________
Caffeinated soda? ( ) No ( ) Yes If yes, how much per day? ________________

Have you ever engaged in any activity which has put you at risk of contracting an STI? ( ) No ( ) Yes

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? ( ) No ( ) Yes
If yes, explain:____

Do you have a Living Will or Advance Directive? ( ) No ( ) Yes

FAMILY MEDICAL HISTORY

Has any family member (including parents, grandparents, and siblings) had the following?

Illness	Which family member(s)?	Approx. Age When Diagnosed
Breast Cancer	______________	______________
Colon/Rectal Cancer	______________	______________
Other Cancer	______________	______________
High Blood Pressure	______________	______________
Heart Attack/Heart Disease	______________	______________
Stroke	______________	______________
Diabetes	______________	______________
Emotional/Mental Illness	______________	______________
Sickle Cell Disease or Trait	______________	______________
Bleeding Clotting Disorder	______________	______________
Asthma/Allergy/Hay	______________	______________

Does anyone in your family have any other major medical problems not mentioned above? If yes, please describe:

____
____
____

Please list any other household or family members living with you (include relationship and date of birth):

____
____
____

PREVENTATIVE HEALTH PRACTICES

Have you had:				
	a Pneumonia shot?	No __	Yes__	If yes, when:__________
	a Flu shot?	No __	Yes__	If yes, when:__________
	a Tetanus shot?	No __	Yes__	If yes, when:__________
	Hepatitis A or B shot?	No __	Yes__	If yes, when:__________

(If female)

Do you do monthly breast self-exam? __________ When was your last breast exam?__________

When was your last pap smear?__________ Any abnormal pap smears?__________

When was your last menstrual period?__________ When was your last mammogram?__________

(If Male)

Do you do monthly testicular self-exam?______________________

MOUNT AIRY FAMILY PRACTICE
PATIENT REGISTRATION FORM
Please Complete Form Leaving No Blank Spaces
Rev 11/7/2013

PATIENT INFORMATION *How did you hear about our office?*____________

Name *(Legal Name)*____

Home Address____________________ City____________ State___ Zip______

Home Phone #(____)______________ Work Phone #(____)______________

E-Mail Address____________________ Cell # (____)______________

Sex: M( ) F ( ) Birthdate:____________ ______________

Employer:________________________ Occupation:______________

Education Level:______________

Work Address:____________________ City____________ State____ Zip______

PERSON TO CONTACT IN AN EMERGENCY

Name:____

Address ____________________ City____________ State___ Zip______

Phone # (___)______________ Relationship____________________

PERSON RESPONSIBLE FOR BILL If different from patient, please complete the following:

Name:____________________ Relationship:__________ Date of Birth______

Address:____________________ City:________ State:___ Zip:__________

______________ Hm#:__________ Wk #:__________